

Annual Report to

**THE NORTH CAROLINA JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE
SERVICES**

***Consumer Deaths Reported and Facility Compliance with
Restraint and Seclusion Policies and Procedures for
State Fiscal Year 2007-2008***

Submitted by

The North Carolina Department of Health and Human Services
Division of Health Service Regulation
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

October 1, 2008

**Consumer Deaths Reported and Facility Compliance with
Restraint and Seclusion Policies and Procedures for
State Fiscal Year 2007-2008**

Table of Contents

| | Page |
|--|--------------|
| EXECUTIVE SUMMARY..... | 3 |
| CONSUMER DEATHS REPORTED | |
| BY PRIVATE FACILITIES..... | 4-9 |
| BY STATE FACILITIES..... | 10 |
| SUMMARY OF DATA..... | 11 |
| COMPLIANCE WITH RESTRAINT/SECLUSION POLICIES AND PROCEDURES | |
| RESTRAINT/SECLUSION CITATIONS REPORTED | |
| FOR PRIVATE FACILITIES..... | 12-19 |
| FOR STATE FACILITIES..... | 20 |
| MOST AND LEAST FREQUENTLY REPORTED CITATIONS | |
| FOR PRIVATE FACILITIES..... | 21 |
| FOR STATE FACILITIES..... | 22 |
| SUMMARY OF DATA..... | 23 |
| APPENDIX..... | 24 |
| LEGAL REQUIREMENTS AND ADMINISTRATIVE RULES | 25 |

EXECUTIVE SUMMARY

The Department of Health and Human Services (DHHS) is required to report certain types of deaths of consumers of mental health, developmental disability, and substance abuse services (legal requirements and administrative rules cited in Appendix). Those deaths include consumers who died of violence, accident, suicide or homicide, and/or whose death occurred within seven days after restraint or seclusion. DHHS is also required to screen and investigate all deaths that may be due to restraint/seclusion, and report facility compliance with restraint and seclusion policies and procedures.

This report presents data on consumer deaths and facility compliance with restraint/seclusion policies and procedures for private and state facilities. The private facilities include: 1) Licensed Assisted Living; 2) Licensed Group Homes, Outpatient, and Day Treatment; 3) Licensed Intermediate Care Programs for Developmentally Disabled; 4) Licensed Psychiatric Units; and 5) Certain Unlicensed facilities. The state facilities include: 1) Intermediate Care Programs for Developmentally Disabled; 2) Psychiatric Hospitals; and 3) Alcohol and Drug Abuse Treatment Centers.

CONSUMER DEATHS REPORTED

A total of 131 private facilities and eight state facilities reported 242 deaths: 190 were reported by private facilities, and 52 were reported by state facilities. Of the 190 deaths reported and screened by private facilities: 154 were investigated, and none were found to be related to restraint/seclusion. Of the 52 deaths reported and screened by state facilities, four were investigated, and one was found to be related to restraint/seclusion.

The following corrective actions were taken in response to the one death found to be related to restraint/seclusion: 1) The facility was cited for non-compliance with restraint/seclusion policies and procedures; 2) An appropriate corrective action plan was developed; and 3) Follow-up monitoring was conducted to verify that the corrective action plan was implemented.

FACILITY COMPLIANCE WITH RESTRAINT/SECLUSION POLICIES AND PROCEDURES

A total of 459 citations were reported for 292 private and 4 state facilities for noncompliance with restraint/seclusion policies and procedures: Of these, 444 were for private facilities; and 15 were for state facilities.

The greatest numbers of citations were given to Private Group Homes, Outpatient Treatment and Day Treatment facilities (401 citations). The most frequently reported citations were for inadequate training in restraint, seclusion, and isolation time out (341 citations); and inadequate training in alternatives to restrictive interventions (52 citations).

The following corrective actions were taken to address the citations: 1) Plans were developed at facilities with the most serious citations; 2) Follow-up monitoring was conducted to verify that those plans were implemented; and 3) A training module was developed on appropriate use of restraint/seclusion.

CONSUMER DEATHS REPORTED

All consumer deaths reported to the Division of Health Services Regulation (DHSR) and/or the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), divisions in DHHS, are screened to determine if an investigation is warranted. The primary objective of this screening and any subsequent investigation is to determine if the facility's use of restraint/seclusion was related to the consumer's death. This report includes data on the number of deaths that were screened, investigated, and found related to restraint or seclusion.

This report presents data on deaths of consumers at private and state facilities. The private facilities include: 1) Licensed Assisted Living; 2) Licensed Group Homes, Outpatient, and Day Treatment; 3) Licensed Intermediate Care Programs for Developmentally Disabled; 4) Licensed Psychiatric Units; and 5) Certain Unlicensed Facilities. The state facilities include: 1) Intermediate Care Programs for Developmentally Disabled; 2) Psychiatric Hospitals; and 3) Alcohol and Drug Abuse Treatment Centers.

North Carolina State Laws and General Statutes (cited in the Appendix) require DHHS to report annually to the North Carolina Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services with the following information:

- The number of deaths reported by each facility;
- The number of deaths investigated pursuant to these statutes; and
- The number of deaths found by investigation to be related to restraint or seclusion.

Due to differences in reporting requirements, caution needs to be taken when comparing deaths across private and state facilities. For example, DMH/DD/SAS providers are required to report the death of any consumer listed on their caseload, even if the consumer was not actively receiving services from the provider at the time of their death. In addition, since 2001, state facilities have been required to report all deaths, which includes those from natural causes, as well as deaths that:

- Resulted from violence, accident, suicide or homicide; and/or
- Occurred within seven days after use of restraint or seclusion.

Please note that, unless otherwise stated, all of the following data on deaths and restraint/seclusion citations was reported in State Fiscal Year (SFY) 2007-2008, which started on July 1, 2007 and ended on June 30, 2008.

CONSUMER DEATHS REPORTED BY PRIVATE FACILITIES

Table 1: Deaths Reported by Private Licensed Assisted Living Facilities¹

| County | Facility | # Deaths Reported and Screened | # Reports Investigated after Screening ² | # Investigations Finding Death Related to R/S ³ |
|--------------|--|--------------------------------|---|--|
| Alexander | A New Outlook of Taylorsville | 1 | 0 | 0 |
| Buncombe | Canterbury Hills Adult Care Home | 1 | 0 | 0 |
| Carteret | The Heritage of Newport | 1 | 1 | 0 |
| Catawba | Piedmont Village at Newton | 1 | 0 | 0 |
| Chatham | Carolina Meadows Fairways | 1 | 1 | 0 |
| Cumberland | Pine Valley Adult Care Home | 1 | 0 | 0 |
| Dare | Spring Arbor of the Outer Banks | 1 | 0 | 0 |
| Durham | Carolina House of Durham | 1 | 0 | 0 |
| Forsyth | Magnolia Creek Assisted Living | 1 | 0 | 0 |
| Gaston | Wellington House | 2 | 1 | 0 |
| Guilford | Arbor Care Assisted Living | 1 | 0 | 0 |
| | Carriage House Senior Living | 2 | 0 | 0 |
| | High Point Manor on Hartley | 2 | 0 | 0 |
| | Oak Hill Rest Home | 1 | 0 | 0 |
| | Wesleyan Arms Retirement Center | 1 | 0 | 0 |
| Harnett | Senter's Rest Home | 2 | 1 | 0 |
| Henderson | Mountain View Assisted Living | 1 | 1 | 0 |
| Johnston | Cardinal Care Assisted Living Village | 1 | 0 | 0 |
| Lenoir | Trinity Manor of Kinston | 1 | 1 | 0 |
| McDowell | McDowell House | 1 | 1 | 0 |
| Mecklenburg | Preston House | 1 | 0 | 0 |
| Moore | Seven Lakes Assisted Living | 1 | 0 | 0 |
| | Tara Plantation of Carthage | 1 | 0 | 0 |
| New Hanover | Hermitage House Rest Home | 1 | 0 | 0 |
| Northampton | St. Mary's Assisted Living | 1 | 0 | 0 |
| Richmond | Somerset Court of Hamlet | 1 | 0 | 0 |
| Robeson | Greystone Manor | 1 | 0 | 0 |
| Rockingham | Holman-Hampton Sunshine FCH #2 | 1 | 0 | 0 |
| Rowan | The Meadows of Rockwell | 2 | 0 | 0 |
| Sampson | Forest Trail Retirement Center | 1 | 1 | 0 |
| Wake | Phoenix Assisted Care | 5 | 0 | 0 |
| | Sunrise Assisted Living at North Hills | 1 | 0 | 0 |
| Wilkes | Mountain House Assisted Living | 1 | 0 | 0 |
| Wilson | Wilson Assisted Living | 1 | 0 | 0 |
| Yadkin | Pinebrook Residential Center #2 | 1 | 0 | 0 |
| Total | Facility Count: 35 | 44 | 8 | 0 |

NOTES

1. There were 1,263 Licensed Assisted Living Facilities with a total of 39,995 beds.
2. For licensed assisted living facilities, the investigation is initiated by a referral of the death report to the County Department of Social Services by the DHSR Complaint Intake Unit after screening.
3. Shading in this column indicates that either an investigation was not warranted, or an investigation found that the death was not related to restraint or seclusion (R/S).

Table 2: Deaths Reported by Private Group Homes, and by Outpatient and Day Treatment Facilities¹

| County | Facility | # Deaths Reported and Screened | # Reports Investigated after Screening | # Investigations Finding Death Related to R/S ² |
|--------------|----------------------------------|--------------------------------|--|--|
| Buncombe | Western Carolina Center | 2 | 2 | 0 |
| Cabarrus | McLeod Addictive Ctr.-Concord | 2 | 2 | 0 |
| Catawba | McLeod Addictive Ctr. Hickory | 5 | 5 | 0 |
| Durham | Durham Treatment Center | 1 | 1 | 0 |
| Forsyth | Insight Human Services | 2 | 2 | 0 |
| Gaston | McLeod Addictive Ctr.- Gastonia | 6 | 6 | 0 |
| | UMAR-Hoffman | 1 | 1 | 0 |
| Haywood | Haywood Co.Group Home #2 | 1 | 1 | 0 |
| Iredell | McLeod's Addictive Ctr. | 2 | 2 | 0 |
| Lincolnton | Jaclyn | 1 | 1 | 0 |
| | Battleground | 1 | 1 | 0 |
| McDowell | McLeod Addictive Center-Marion | 3 | 3 | 0 |
| Mecklenburg | McLeod Addictive Ctr.-Youngblood | 5 | 5 | 0 |
| New Hanover | Southeastern Ctr. for MH/DD/SAS | 1 | 1 | 0 |
| | El Ogden | 1 | 1 | 0 |
| Onslow | Greenbriar-J | 1 | 1 | 0 |
| Rockingham | Remmsco Women's Home | 1 | 1 | 0 |
| Wake | Goshawk Lane | 2 | 2 | 0 |
| | Biltmore Center | 2 | 2 | 0 |
| Watuaga | McLeod Addictive Ctr.- Boone | 6 | 6 | 0 |
| Total | Facility Count: 20 | 46 | 46 | 0 |

NOTES

1. There were 3,634 of these types of facilities, with a total of 13,865 beds.
2. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

Table 3: Deaths Reported by Private Intermediate Care Facilities for the Developmentally Disabled¹

| County | Facility | # Deaths Reported and Screened ² | # Reports Investigated after Screening | # Investigations Finding Death Related to R/S ³ |
|--------------|--------------------------|---|--|--|
| Cabarrus | RHA/Howells-Clearcreek | 1 | 1 | 0 |
| Wake | Tammy Lynn Center | 1 | 1 | 0 |
| Total | Facility Count: 2 | 2 | 2 | 0 |

NOTES

1. There were 328 of these types of facilities with a total of 2,570 beds.
2. All deaths reviewed at time of recertification.
3. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

Table 4: Deaths Reported by Private Psychiatric Facilities¹

| County | Facility | # Deaths Reported and Screened | # Reports Investigated after Screening | # Investigations Finding Death Related to R/S ² |
|--------------|------------------------------|--------------------------------|--|--|
| Alexander | Frye Regional Medical Center | 1 | 1 | 0 |
| Buncombe | Memorial Mission Hospital | 1 | 1 | 0 |
| Total | Facility Count: 2 | 2 | 2 | 0 |

NOTES

1. There were 6 private psychiatric hospitals, 40 hospitals with acute care psychiatric units, 15 psychiatric residential treatment facilities, 4 wilderness camps, and 8 foster care camps, with a total of 2,986 beds.
2. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

Table 5: Deaths Reported by Certain Unlicensed Private Facilities¹

| County | Facility | # Deaths Reported and Screened | # Reports Investigated after Screening ² | # Investigations Finding Death Related to R/S ³ |
|-------------|------------------------------------|--------------------------------|---|--|
| Anson | Finding Your Way | 1 | 1 | 0 |
| | Sandhills Center for MD/DD/SAS | 1 | 1 | 0 |
| | Superior Healthcare Services | 1 | 1 | 0 |
| Ashe | New River Behavioral Healthcare | 2 | 2 | 0 |
| Avery | CNC Access | 1 | 1 | 0 |
| | New River Behavioral Healthcare | 1 | 1 | 0 |
| Buncombe | Families Together, Inc | 2 | 2 | 0 |
| | Family Preservation Services | 1 | 1 | 0 |
| | October Road Inc. | 1 | 1 | 0 |
| | RHA Behavioral | 1 | 1 | 0 |
| | Universal Mental Health Services | 2 | 2 | 0 |
| Burke | Catawba Valley Behavioral Health | 3 | 3 | 0 |
| Cabarrus | Daymark Recovery Service | 2 | 2 | 0 |
| Caldwell | Foothills Area MD/DD/SAS Authority | 1 | 1 | 0 |
| Catawba | Catawba Valley Behavioral Health | 4 | 4 | 0 |
| | Family Net | 1 | 1 | 0 |
| Cherokee | Meridian Behavioral Health | 1 | 1 | 0 |
| Cleveland | Cleveland Family Services | 1 | 1 | 0 |
| | True Behavioral Healthcare, Inc. | 1 | 1 | 0 |
| Columbus | Family Alternatives, Inc. | 1 | 1 | 0 |
| Craven | Port Human Services | 1 | 1 | 0 |
| Davidson | Daymark Recovery Services | 1 | 1 | 0 |
| Davie | Daymark Recovery Services | 1 | 1 | 0 |
| Durham | B & D Behavioral Health Services | 1 | 1 | 0 |
| | Criminal Justice Resource Center | 1 | 1 | 0 |
| | Dominion Healthcare | 1 | 1 | 0 |
| Forsyth | Daymark Recovery Services | 2 | 2 | 0 |
| Gaston | CRE Care Management | 1 | 1 | 0 |
| | Easter Seals-United Cerebral Palsy | 1 | 1 | 0 |
| Guilford | Quality Life Services Inc. | 1 | 1 | 0 |
| Halifax | CareFocus | 1 | 1 | 0 |
| Henderson | Advantage Home & Comm. Care | 1 | 1 | 0 |
| Hoke | Sandhills Center for MH/DD/SAS | 1 | 1 | 0 |
| Jackson | Jackson County Psychological | 1 | 1 | 0 |
| | Meridian Behavioral Health | 1 | 1 | 0 |
| | Phoenix Supported Living | 1 | 1 | 0 |
| Johnston | Johnston County Area MH/DD/SAS | 2 | 2 | 0 |
| Madison | Alpha-Omega Health Inc | 1 | 1 | 0 |
| Mecklenburg | Alexander Youth Network | 1 | 1 | 0 |
| | Mecklenburg Provided Services | 1 | 1 | 0 |
| Mitchell | Alpha Omega Health | 1 | 1 | 0 |
| New Hanover | Coastal Horizons Center | 1 | 1 | 0 |
| | Community Support Professionals | 1 | 1 | 0 |
| | Evergreen Behavioral | 1 | 1 | 0 |
| Onslow | Onslow Carteret Behavioral Health | 1 | 1 | 0 |
| Orange | Caring Family Network | 1 | 1 | 0 |
| Pamlico | PORT Human Services | 1 | 1 | 0 |
| Pitt | ARC Services, Inc. | 1 | 1 | 0 |
| | Port Human Services | 1 | 1 | 0 |

Table 5: Deaths Reported by Certain Unlicensed Private Facilities¹ (Continued)

| | | | | |
|--------------|-------------------------------------|-----------|-----------|----------|
| Randolph | Sandhills Center for MH/DD/SAS | 3 | 3 | 0 |
| Roberson | Coordinated Health Services | 1 | 1 | 0 |
| | Carolina Professional Mental Health | 1 | 1 | 0 |
| Rockingham | Rockingham Mental Health | 4 | 4 | 0 |
| | TX Accountability for Safer Comm. | 1 | 1 | 0 |
| | Tri-Care Professional | 1 | 1 | 0 |
| Rowan | Excel Personal Development | 1 | 1 | 0 |
| Rutherford | Family Preservation Services of NC | 4 | 4 | 0 |
| Stanley | Daymark Recovery Services | 1 | 1 | 0 |
| | Mental Health Association of NC | 2 | 2 | 0 |
| | ARC Services/Foundations | 1 | 1 | 0 |
| | Monarch | 1 | 1 | 0 |
| Surry | Crossroads Behavioral Healthcare | 1 | 1 | 0 |
| Union | Daymark Recovery Services | 4 | 4 | 0 |
| Vance | Triumph, LLC | 1 | 1 | 0 |
| Wake | Fellowship Health Resources | 1 | 1 | 0 |
| | Psych. Supports | 1 | 1 | 0 |
| | Triumph, LLC | 1 | 1 | 0 |
| Watauga | New River Behavioral Healthcare | 2 | 2 | 0 |
| Wilson | Health Services Personnel | 1 | 1 | 0 |
| | PORT Human Services | 1 | 1 | 0 |
| | Pride in NC | 1 | 1 | 0 |
| Yancey | Alpha-Omega Health | 1 | 1 | 0 |
| Total | Facility Count: 72 | 96 | 96 | 0 |

NOTES:

1. This table includes private facilities not licensed in accordance with G.S. 122C, Article 2, and facilities not operated by the state in accordance with G.S. 122 C Article 4, Part 5.
2. All of the deaths listed in this column were investigated by the Local Management Entity (LME) responsible providing oversight, and the findings were reviewed by DMH/DD/SAS.
3. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

CONSUMER DEATHS REPORTED BY STATE FACILITIES

Table 6: Deaths Reported by State Intermediate Care Facilities for the Developmentally Disabled¹

| County | Facility | # Deaths Reported and Screened | # Reports Investigated after Screening | # Investigations Finding Death Related to R/S ² |
|--------------|-----------------------------|--------------------------------|--|--|
| Burke | Riddle Developmental Center | 5 | 0 | 0 |
| Granville | Murdoch Center | 9 | 0 | 0 |
| Lenoir | Caswell Center | 16 | 0 | 0 |
| Wayne | O'Berry Center | 9 | 0 | 0 |
| Total | Facility Count: 4 | 39 | 0 | 0 |

NOTES:

1. These 4 facilities have an operating capacity of 1691 beds during this reporting period.
2. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

Table 7: Deaths Reported by State Psychiatric Hospitals¹

| County | Facility | # Deaths Reported and Screened ² | # Reports Investigated after Screening | # Investigations Finding Death Related to R/S ³ |
|--------------|---------------------------------|---|--|--|
| Burke | Broughton Hospital ³ | 2 | 2 | 1 |
| Granville | John Umstead Hospital | 4 | 2 | 0 |
| Wake | Dorothea Dix Hospital | 5 | 0 | 0 |
| Wayne | Cherry Hospital | 2 | 0 | 0 |
| Total | Facility Count: 4 | 13 | 4 | 1 |

NOTES:

1. There were 4 of these facilities with 1,297 operational beds.
2. These figures include a death reported in February, 2007 and investigated in April of 2007. This investigation did not find that the death was related to restraint/seclusion. A subsequent investigation was conducted in August of 2007 in response to a complaint. This investigation found that the death was related to restraint/seclusion, and thus it is included in this report.
3. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

Table 8: Deaths Reported by State Alcohol and Drug Abuse Treatment Centers¹

| County | Facility | # Deaths Reported and Screened | # Reports Investigated after Screening | # Investigations Finding Death Related to R/S ² |
|--------------|-----------------------------------|--------------------------------|--|--|
| | No deaths reported for facilities | 0 | 0 | 0 |
| Total | Facility Count: 0 | 0 | 0 | 0 |

NOTES:

1. There were 3 of these facilities, with a total of 236 beds.
2. Shading in this column indicates that either an investigation was not warranted, or an investigation found the death was not related to restraint or seclusion (R/S).

SUMMARY OF DATA ON CONSUMER DEATHS REPORTED FOR SFY 2007-2008

A total of 131 private facilities and eight state facilities reported 242 deaths:

- 190 of these deaths were reported by private facilities
- 52 of these deaths were reported by state facilities

Of the 190 deaths reported and screened by private facilities:

- 154 deaths were investigated
- No deaths were found to be related to restraint or seclusion

Of the 52 deaths reported and screened by state facilities:

- Four deaths were investigated
- One death was found to be related to restraint or seclusion

The following actions were taken in response to the one death found to be related to restraint/seclusion:

- The facility was cited for non-compliance with restraint/seclusion policies and procedures
- An appropriate corrective action plan was developed
- Follow-up monitoring was conducted to verify that the corrective action plan was implemented

Facility Compliance with R/S Policies and Procedures

RESTRAINT/SECLUSION CITATIONS FOR PRIVATE FACILITIES

Table 9: R/S Citations for Private Licensed Assisted Living Facilities

| County | Facility | # Citations |
|--------------|----------------------------------|-------------|
| Bertie | Windsor House | 1 |
| Buncombe | Evergreen Living #3 | 1 |
| Caswell | Double S and H Family Care Home | 1 |
| | G. Anthony Rucker | 1 |
| Cleveland | Somerset of Shelby | 1 |
| Cumberland | Hope Mills Retirement | 1 |
| Edgecombe | Heritage Care Of Rocky Mount | 2 |
| Forsyth | Clemmons Village | 1 |
| Granville | Toney's Rest Home | 1 |
| Guilford | Greensboro Retirement Center | 1 |
| Harnett | Oak Hill Living Center | 1 |
| | Senter's Rest Home | 1 |
| Haywood | Haywood Retirement | 1 |
| Mecklenburg | The Haven in the Village | 1 |
| Nash | Spring Arbor of Rocky Mount | 1 |
| New Hanover | Glencare of Wilmington | 1 |
| Randolph | Triad Telecare, DBA Country Club | 1 |
| Rutherford | Oakland Living | 1 |
| Union | Monroe Manor Rest Home | 1 |
| Wake | The Oliver House | 1 |
| Total | Facility Count: 20 | 21 |

Table 10: R/S Citations for Private Group Homes and for Outpatient and Day Treatment Facilities

| County | Facility | # Citations |
|-----------|--|-------------|
| Alamance | Hyde House | 2 |
| | Lakeview Avenue Group Home | 2 |
| | McPherson Street Group Home | 2 |
| | North Mebane Street Group Home | 3 |
| | Redeem House | 2 |
| | Save Our Children Coalition | 2 |
| | Sixth Street DDA Group Home | 1 |
| | Stinson's DDA #2 | 1 |
| | Triad Health Care Services #1 | 2 |
| | Triad Health Care Services #2 | 2 |
| Avery | Grandfather Home for Children-Banner Elk | 1 |
| Beaufort | Beaufort County GH #1 | 2 |
| | Destiny Home of Beaufort County | 1 |
| | Excel for Life | 1 |
| | Wooded Acres #3 | 1 |
| Bertie | Cherry's Group Home #1 | 2 |
| | Jamar House | 1 |
| | Rayann House | 1 |
| Brunswick | Birges | 1 |
| | Ivory's Home | 2 |
| | The House of Eve | ` |
| Buncombe | Carolina Mountain Group Home | 1 |
| | Farm School Home | 1 |
| | Green Acres | 1 |
| | Hillside Group Home | 1 |
| | Western Carolina Treatment Center | 1 |
| Burke | Crescent House | 1 |
| | Flynn Fellowship Christian Home | 1 |
| Cabarrus | Brookwood | 5 |
| | Cabarrus County Group Home-Camelot | 1 |
| | James Place | 1 |
| | McLeod –Concord | 1 |
| | Old Charlotte #2 | 4 |
| Caldwell | Walkers – Bud Brown Home | 1 |
| Catawba | Andrea's Place | 1 |
| | Blevins House | 1 |
| | Catawba County Group Home #4 | 1 |
| Chatham | Chatham Group Home #1 | 2 |
| | Chatham Group Home #2 | 2 |
| | Chatham Group Home #3 | 2 |
| | Gray Alternative Care | 2 |
| | Griffin House | 1 |
| | Hope Meadow | 1 |
| | Nooe House A | 2 |
| | Perkins Place | 1 |
| | Winfred West | 1 |
| Cleveland | Essentially Living | 1 |
| | Lake Drive | 1 |
| | Mills Creek | 1 |
| | Tracy Street Home | 1 |
| | Transitions | 2 |

Table 10: R/S Citations for Private Group Homes and for Outpatient and Day Treatment Facilities (Continued)

| County | Facility | # Citations |
|------------|-------------------------------------|-------------|
| Cumberland | A Positive Life | 1 |
| | Building Joy in Healthcare | 3 |
| | Golden Opportunity #2 | 1 |
| | Omega IV | 1 |
| Davidson | Rainbow of Sunshine | 2 |
| | The Arlington House | 1 |
| | Woodbridge Academy | 1 |
| | Woodbridge Alternative Cadmium | 2 |
| | Woodbridge at Rosehill | 1 |
| | Arlington House | 2 |
| | Fairview House | 2 |
| | Joshua House | 1 |
| | Milling Manor | 2 |
| Duplin | Path of Hope 029-006 | 2 |
| | Path of Hope 029-007 | 2 |
| Durham | Helen House | 1 |
| | The Lawson House | 1 |
| | Greenhouse for Girls | 1 |
| | Haven Group Home | 1 |
| | Kinder Love Home | 2 |
| | Providence Place | 1 |
| Edgecomb | Better Days Ahead of Rocky Mount, I | 1 |
| Forsyth | A New Way of Life | 2 |
| | Aldersgate | 2 |
| | Ansley Home | 2 |
| | Children's Home – Bristol | 1 |
| | Friendly People That Care | 1 |
| | Hines | 1 |
| | Insight Human Services | 2 |
| | Old Vineyard | 3 |
| | Spanish Oaks | 3 |
| | UMAR – Hooper | 1 |
| | | |
| Gaston | CBAY Limerick | 2 |
| | Cornerstone Christian Center | 1 |
| | Downey Place | 1 |
| | Essential Home #2 Stanley | 2 |
| | Flynn Home | 1 |
| | Gentlemen's Quarters | 1 |
| | Mainstay | 1 |
| | McGregor II | 1 |
| | Monument Home | 1 |
| | Nims Avenue | 1 |
| | The Trenton House | 1 |
| | The House of David | 2 |
| | | |
| Greene | Edwards Group Home #4 | 1 |
| | Mary Taylor Homes | 1 |

Table 10: R/S Citations for Private Group Homes and for Outpatient and Day Treatment Facilities (Continued)

| County | Facility | # Citations |
|----------|---|-------------|
| Guilford | Achievement Place | 1 |
| | Adolescent Alternatives | 1 |
| | Alcoholic's House of Prayer | 1 |
| | Austin's Place | 3 |
| | Berryman House | 1 |
| | Bowman | 2 |
| | Brighter Path Family Care #1 | 5 |
| | Britton Street | 1 |
| | Bryson's Place | 2 |
| | Caldwell Group Home | 2 |
| | Carter Group Home | 2 |
| | Center Of Progressive Strides | 2 |
| | Coltrane's | 3 |
| | Courtfield Place | 1 |
| | Dawbea Place | 1 |
| | Bowman | 2 |
| | Brighter Path Family Care #1 | 5 |
| | Britton Street | 1 |
| | Bryson's Place | 2 |
| | Caldwell Group Home | 2 |
| | Carter Group Home | 2 |
| | Center Of Progressive Strides | 2 |
| | Coltrane's | 3 |
| | Courtfield Place | 1 |
| | Dawbea Place | 1 |
| | Dobson Road Home | 1 |
| | Dream Treatment Services | 1 |
| | Envisions of Life | 1 |
| | Ezcare Providers | 5 |
| | Facing Challenges | 2 |
| | First Genesis Group Home | 1 |
| | Fleming Trace | 2 |
| | Garvin's Mental Management | 1 |
| | Genesis Professionals, LLC | 2 |
| | GHHM-Northridge | 1 |
| | Good Shephard Group Home | 1 |
| | Grand Summit | 2 |
| | Guilford Substance Abuse Treatment Facility | 2 |
| | Hope House | 3 |
| | Joyce House | 2 |
| | Lexington House | 1 |
| | Linsher Cares | 2 |
| | Lockwood #2 | 5 |

Table 10: R/S Citations for Private Group Homes and for Outpatient and Day Treatment Facilities (Continued)

| County | Facility | # Citations |
|---------------|--|--------------------|
| Guilford | Lockwood Place | 1 |
| | Mag's House | 5 |
| | Mary's House | 1 |
| | Mell Burton Day Treatment | 2 |
| | Miracle of Faith Family Care | 1 |
| | Morris Manor | 2 |
| | Our Home Aunt Zola's | 2 |
| | Piedmont Home | 1 |
| | Positive Care 041-595 | 3 |
| | Positive Care 2 #041-633 | 2 |
| | Positive Care 3 #041-765 | 3 |
| | Precious Pearls | 2 |
| | Rising Phoenix | 2 |
| | RJ Whitsett #3 | 1 |
| | Robbins Group Home | 2 |
| | Morris Manor | 2 |
| | Sloan House | 2 |
| | Spring House | 1 |
| | The Baker House | 1 |
| | Tri - Support | 2 |
| | Trinity House LLC | 1 |
| | Wynmere Place | 2 |
| | York House | 2 |
| Harnett | Robin Hill | 1 |
| | Sierra's Residential Services, Inc | 1 |
| | Woodhaven Family Care Facility | 1 |
| Hoke | McEachin Treatment Facility, Inc | 2 |
| | Potter's House Outreach Corporation | 1 |
| | Regina's Touch | 2 |
| Iredell | Crisis Recovery Center | 1 |
| | Whalen House | 1 |
| | Whalen House | 1 |
| Johnston | Impact Youth & Family Services | 2 |
| | Stancil Therapeutic Home | 1 |
| | Tender Love Independent Home Care | 1 |
| | United Family Network at Ridge Road | 1 |
| Lenoir | Ackerman House | 1 |
| | Pinewood | 1 |
| Lincoln | East Pine Street | 1 |
| | Sycamore Street | 1 |
| Martin | Amani Residential | 1 |
| McDowell | McLeod Addictive Disease Center – Marion | 1 |
| | Nebo Group Home | 1 |

Table 10: R/S Citations for Private Group Homes, and for Outpatient and Day Treatment Facilities (Continued)

| County | Facility | # Citations |
|-------------|---------------------------------------|-------------|
| Mecklenburg | Alexander Children Center – Barnhardt | 2 |
| | CASCADE Services | 1 |
| | Connell Home | 1 |
| | Keys of Carolina | 3 |
| | McLeod Addictive Center – Charlotte | 1 |
| | Mr. Bill's Place | 2 |
| | New Beginnings- | 2 |
| | Old Charlotte 2 | 1 |
| | RHA/Howell Center – Nevins #1 | 1 |
| | St. Michael's #1 Fairlawn | 2 |
| | Villages of Hope Haven | 1 |
| Nash | BTW Home Care | 1 |
| | Edwards Residential Care | 1 |
| New Hanover | Brodick Court | 4 |
| | Newbury Way | 1 |
| | Stepping Stone Manor | 2 |
| Orange | Aberdeen Group Home | 2 |
| | Apogee Home One | 1 |
| | Ephesus | 1 |
| | RSI- Gary Road | 2 |
| | RSI-Clayton | 1 |
| | RSI-Ferrell Road | 2 |
| | RSI-Oleander | 2 |
| | RSI-Purefoy | 1 |
| | RSI-Umstead Road | 2 |
| | RSI-Woodcrest | 2 |
| | UNC Sunrise CASAWORKS | 1 |
| Pasquotank | Oakdale Drive | 1 |
| Person | McDaniel Home #2 | 1 |
| Pitt | Evans Home | 1 |
| | Paradigm | 1 |
| | WeCare Residential Facility | 1 |
| Polk | Cooperiis | 1 |
| Richmond | Steele St. House | 1 |
| Robeson | Fairley Support | 1 |
| | Loving Tree Center | 7 |
| | South Edinborough Residential | 1 |
| | The Rossberry Home of Fairmont | 5 |
| Rockingham | Challenges #1 | 2 |
| | Daystar #1 | 2 |
| | Daystar #4 | 2 |
| | Daystar #5 | 2 |
| | Life Turn | 2 |
| | Rockingham ARC #6 | 1 |
| | Youth Haven Services | 2 |

Table 10: R/S Citations for Private Group Homes, and for Outpatient and Day Treatment Facilities (Continued)

| County | Facility | # Citations |
|---------------|--------------------------------------|--------------------|
| Rowan | Betty Home | 2 |
| | Bringle Ferry | 3 |
| | Liberty House | 1 |
| | Timber Ridge Treatment Center | 2 |
| Rutherford | Chase Place | 2 |
| | Commonwood Home | 1 |
| | New Alternatives I | 1 |
| Stanly | 2304 Edgewood Street | 1 |
| | Lincoln Street Group Home | 1 |
| | Pinnacle Homes 1 | 1 |
| | Troy Group Home | 1 |
| | Valleyview Group Home | 1 |
| Stokes | Pinnacle Homes 2 | 1 |
| Surry | Elkin Group Home | 1 |
| | Maple Street Home | 1 |
| | Peace Lily I | 1 |
| | Peace Lily I | 1 |
| | Peace Lily II | 1 |
| Union | Friendship House | 1 |
| | Serenity Hills | 1 |
| Wake | Currituck Home | 3 |
| Warren | Gavin & Downey Heavenly Living GH #2 | 1 |
| Watauga | Turning Point Respite Home | 1 |
| Wayne | Graham New Horizons | 2 |
| | Manuel's Supportive Living | 1 |
| | Maple House | 1 |
| Wilkes | Synergy Recovery at Bundy Center | 1 |
| Wilson | Dunn's House of Love & Devoted Care | 1 |
| | Miss Daisy's | 2 |
| | Miss Daisy's Homesite | 2 |
| | The Wellman Center #1 | 1 |
| | The Wellman Center #2 | 2 |
| | Virginia Dare Home | 1 |
| Yadkin | Mucus Road Home | 1 |
| Total | Facility Count: 256 | 401 |

Table 11: R/S Citations Reported for Private Intermediate Care Facilities for the Developmentally Disabled

| County | Facility | # Citations |
|--------------|--|-------------|
| Halifax | Life, Inc./Lakeview | 1 |
| | Life, Inc./King Street | 2 |
| Henderson | Rayside A and B | 1 |
| Moore | Moore County Adult Autistic Group Home | 1 |
| Roberson | Westside Residential | 1 |
| Total | Facility Count: 5 | 6 |

Table 12: R/S Citations Reported for Private Psychiatric Facilities

| County | Facility | # Citations |
|--------------|--------------------------------|-------------|
| Beaufort | Beaufort County Hospital | 3 |
| Burke | Grace Hospital | 1 |
| Buncombe | Memorial Mission | 1 |
| Durham | Durham Regional Hospital | 2 |
| Forsyth | Forsyth Memorial Hospital | 1 |
| | NC Baptist Hospital | 1 |
| | Old Vineyard | 2 |
| Mecklenburg | Carolinas Medical Center | 1 |
| Onslow | Byrnn Marr | 1 |
| Pitt | Pitt Memorial Hospital | 2 |
| Roberson | Southeastern Regional Hospital | 1 |
| Total | Facility Count: 11 | 16 |

Table 13: R/S Citations Reported for Certain Unlicensed Facilities¹

| County | Facility | # Citations |
|--------------|--|-------------|
| | No citations reported for these facilities | |
| Total | Facility Count: 0 | 0 |

NOTE:

1. Includes private facilities not licensed in accordance with G.S. 122C, Article 2, and facilities not operated by the state in accordance with G.S. 122 C Article 4, Part 5.

Restraint/Seclusion (R/S) Citations Reported for State Facilities

Table 14: R/S Citations for State Intermediate Care Facilities for the Developmentally Disabled

| County | Facility | # Citations |
|--------------|--|-------------|
| | No citations reported for these facilities | |
| Total | Facility Count: 0 | 0 |

Table 15: R/S Citations for State Psychiatric Hospitals

| County | Facility | # Citations |
|--------------|--------------------------|-------------|
| Burke | Broughton Hospital | 4 |
| Granville | John Umstead Hospital | 5 |
| Wake | Dorthea Dix Hospital | 1 |
| Wayne | Cherry Hospital | 5 |
| Total | Facility Count: 4 | 15 |

Table 16: R/S Citations for State Alcohol and Drug Abuse Treatment Centers

| County | Facility | # Citations |
|--------------|--|-------------|
| | No citations reported for these facilities | |
| Total | Facility Count: 0 | 0 |

MOST AND LEAST FREQUENTLY REPORTED CITATIONS

Table 17: Most and Least Frequent Citations for Private Facilities

| Type of Facility | Restraint/Seclusion Citations | | |
|--|-------------------------------|---|---|
| | Total # | Most Frequently Reported | Least Frequently Reported |
| LICENSED ASSISTED LIVING | 21 | <ul style="list-style-type: none"> Inappropriate use of restraints (18 citations) | <ul style="list-style-type: none"> Failure to get informed consent on restraint use (2 citation) Inadequate assessment and care planning (1 citation) |
| GROUP HOME & OUTPATIENT DAY TREATMENT | 401 | <ul style="list-style-type: none"> Inadequate training in restraint and seclusion (341 citations) Inadequate training on use of alternatives to restrictive interventions (52 citations) | <ul style="list-style-type: none"> Use of protective devices (1 citation) Prohibited restraint/ seclusion procedures (2 citations) |
| Intermediate Care Facilities for the Developmentally Disabled | 6 | <ul style="list-style-type: none"> Not integrating restraint into Individual's care plan (3 citations) Not checking at least every 30 minutes when a restraint is used and not recording those checks (2 citations) | <ul style="list-style-type: none"> Inappropriate use of gait belt as a chair restraint (1 citation) |
| Psychiatric Treatment | 16 | <ul style="list-style-type: none"> Not integrating restraint into consumer's individual program plan (5 citations) Not conducting restraint in accordance with attending physician's order (5 citations) | <ul style="list-style-type: none"> The other citations were for five different types of violations of restraint/ seclusion policy and procedure (6 citations). |
| Certain Unlicensed Facilities¹ | 0 | No citations reported for these facilities | |

NOTE:

- Includes private facilities not licensed in accordance with G.S. 122C, Article 2; however, it does not include state facilities operating in accordance with G.S. 122 C Article 4, Part 5.

Table 18: Most and Least Frequent R/S Citations for State Facilities

| Type of Facility | Restraint/Seclusion Citations | | |
|--|--------------------------------------|---|----------------------------------|
| | Total # | Most Frequently Reported | Least Frequently Reported |
| Intermediate Care Facilities for the Developmentally Disabled | 0 | <ul style="list-style-type: none"> No citations reported for these facilities | |
| Psychiatric Hospitals | 15 | <ul style="list-style-type: none"> Restraint/seclusion not conducted in accordance with attending physician's order (3 citations) Restraint/seclusion not implemented safely or appropriately (3 citations) Restraint/seclusion used when less restrictive interventions have been found to be effective for similar incidents (2 citations) Insufficient monitoring of consumer during restraint/seclusion (2 citations) Other types of noncompliance with restraint/seclusion policy/procedure (5 citations) | |
| Alcohol and Drug Abuse Treatment Centers | 0 | <ul style="list-style-type: none"> No citations reported for these facilities | |

SUMMARY OF DATA ON RESTRAINT/SECLUSION CITATIONS FOR SFY2007-2008

A total of 459 citations were reported for 292 private and 4 state facilities for noncompliance with restraint/seclusion policies and procedures:

- 444 of these citations were from private facilities; and
- 15 of these citations were from state facilities.

The types of facilities with the most number of citations (401) were:

- Private Group Homes
- Outpatient Treatment
- Day Treatment

The most frequently reported citations were:

- Inadequate training in restraint and seclusion (341 citations)
- Inadequate training in alternatives to restrictive interventions (52 citations)

The following corrective actions were taken to address the citations:

- Plans were developed at facilities with the most serious citations
- Follow-up monitoring was conducted to verify that plans were implemented
- DHSR developed a training module on appropriate use of restraint/seclusion

Appendix

Legal Requirements and Administrative Rules

North Carolina's Session Laws (S.L.), General Statutes (G.S.), House Bills (H.B.) and Administrative Codes specify legal requirements and administrative rules for reporting consumer deaths and addressing facility compliance with restraint/ seclusion policies and procedures. In particular, G.S. 122C-31, G.S.131D-10.6B, and G.S. 131D-34.1, as amended by S.L. 2000-129 (H.B. 1520) and S.L. 2003-58 (H.B. 80), requires certain types of facilities to notify the Department of Health and Human Services (DHHS) of deaths that:

- Resulted from violence, accident, suicide or homicide; or
- Occurred within seven days after use of restraint or seclusion.

In addition, S.L. 2000-129, Section 3(b), 5(b) and 6(b), as amended by S.L. 2003-58, Sections 1-4, requires DHHS to report those deaths annually to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. G.S. 122C-31, G.S. 131D-10.6, and G.S. 131D-34.1 specifies that those reports include the following information:

- The number of deaths reported by each facility;
- The number of deaths investigated pursuant to those statutes; and
- The number of deaths found by investigation to be related to restraint/seclusion.

Furthermore, S.L. 2000-129 and S.L. 2003-58 requires DHHS to report facility compliance with restraint/seclusion policies and procedures. Toward this end, DHHS collected data from on-site investigations, inspections and monitoring visits, and included the following information in this report as well as in previous reports:

- Citations for noncompliance with restraint/seclusion policies and procedures; and
- The most and least frequently reported restraint/seclusion citations.

North Carolina Administrative Code (NCAC), in 10A 26C .0301 and 10A 27G .0600, provides specific instructions for reporting consumer deaths:

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **state facilities** operating in accordance with G.S. 122C Article 4, Part 5, and **inpatient psychiatric units of hospitals** licensed under G.S. 131E, report deaths to the **Division of Health Service Regulation (DHSR)**.
- **MH/DD/SAS facilities not requiring licensure** and facilities licensed in accordance with G.S. 122C Article 2, report deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS)**.

In general, changes made in legal reporting requirements in one state fiscal year are reflected in data reported for the next state fiscal year.